BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Edmund Ayoub, Jr. , M.D. Physician's and Surgeon's Certificate No. A 104389 Respondent.	Case No.: 800-2020-071648

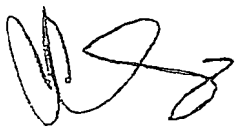
DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on January 5, 2023.

IT IS SO ORDERED: December 6, 2022.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

EDMUND AYOUB, JR., M.D.

Physician's and Surgeon's Certificate No. A 104389

Respondent.

Agency Case No. 800-2020-071648

OAH No. 2022040020

PROPOSED DECISION

Cindy F. Forman, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on October 10, 2022.

Jonathan Nguyen, Deputy Attorney General, represented complainant William Prasifka, Executive Director of the Medical Board of California (Board), Department of Consumer Affairs (Department).

Respondent Edmund Ayoub, Jr., M.D., made no appearance at the hearing.

The ALJ received testimony and documentary evidence at the hearing. The ALJ re-opened the record briefly after the hearing to allow the submission of two emails from respondent to Jusua Barbosa of the Department of Justice (DOJ) regarding respondent's participation in this hearing, the first dated October 5, 2022, and marked Exhibit 15, and the second dated October 7, 2022, marked as Exhibit 16. The ALJ admitted both exhibits into evidence. The ALJ then re-closed the record, and the matter was submitted for decision on October 10, 2022.

By her own motion, the ALJ redacted Patient A's name for privacy purposes from the transcript of the interview with respondent admitted as Exhibit 10.

SUMMARY

Complainant seeks to discipline respondent's medical license based on gross negligence, repeated acts of negligence, poor record keeping, and unprofessional conduct in connection with respondent's care of a single patient between December 2015 and September 2018. Complainant established by clear and convincing evidence respondent's conduct warranted discipline. However, based on respondent's lack of prior discipline, the limited scope of his misconduct, and other mitigation evidence, revocation of his license would be unduly punitive. The Board's recommended discipline of five years of probation, with conditions requiring a competency evaluation, practice supervision, and additional education courses, is appropriate to assure public protection.

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FACTUAL FINDINGS

Jurisdiction and Parties

1. The Board issued Physician's and Surgeon's Certificate Number A 104389 (license) to respondent on June 13, 2008. Respondent's license is scheduled to expire on September 23, 2023.

2. On January 4, 2022, complainant executed the Accusation in his official capacity. The Accusation seeks to discipline respondent's license based on his treatment of Patient A (who shall remain unidentified to protect her privacy). According to the Accusation, respondent is subject to disciplinary action because he engaged in gross negligence in his treatment of Patient A in violation of Business and Professions Code section 2234, subdivision (b) (all further undesignated section references are to the Business and Professions Code); committed repeated negligent acts in his care of Patient A in violation of section 2234, subdivision (c); failed to maintain adequate and accurate medical records of Patient A's care in violation of section 2266; and engaged in unprofessional conduct in violation of section 2234.

3. Respondent timely filed a Notice of Defense on January 10, 2022, requesting a hearing on the merits of the Accusation. The Notice of Defense indicates respondent was represented by counsel at the time of filing. Respondent and his counsel appeared at the Prehearing Conference and Mandatory Settlement Conference held in this matter on August 26, 2022.

4. On September 29, 2022, respondent informed complainant's counsel in writing that from that time forward, he would represent himself in this action without the assistance of counsel and that all correspondence should be directed to him, not

his former attorney. (Ex. 12.) In an email dated October 4, 2022, respondent informed complainant's counsel he would not be appearing or defending himself in the hearing on the Accusation. (Ex. 13.) Nonetheless, on October 4, 2022, complainant's counsel, through Jusua Barbosa of the DOJ, emailed and sent by overnight mail to respondent a copy of the Notice of Hearing in this matter and prehearing documents. On October 5, 2022, respondent acknowledged receipt of the email and directed Mr. Barbosa to speak with complainant's counsel. (Ex. 15.) On October 6, 2022, Mr. Barbosa sent respondent by email copies of the exhibits complainant's counsel intended to use at this proceeding. On October 7, 2022, respondent emailed Mr. Barbosa stating he objected to the conduct of the hearing by an ALJ. (Ex. 16.)

5. Despite proper service of the Notice of Hearing on respondent, respondent failed to appear at the October 10, 2022 hearing and was not otherwise represented. Compliance with Government Code sections 11505 and 11509 having been established, this matter proceeded as a default against respondent pursuant to Government Code section 11520. Under Government Code section 11520, the Board may take action "based upon the respondent's express admissions or upon other evidence."

Charges in the Accusation

6. This action was triggered by a complaint about respondent's conduct filed by Patient A (the patient is unnamed to protect her privacy) on October 8, 2020. (Ex. 8.) As a result of the complaint, the Board initiated an investigation into respondent's care and treatment of Patient A. As part of that investigation, investigators from the Department's Health Quality Investigation Unit (HQIU) interviewed respondent on April 13, 2021. HQUI also requested Doris Y. Chih, M.D., to review respondent's medical records for Patient A. After receipt of Dr. Chih's findings,

complainant filed the Accusation. The Accusation does not address or repeat any of the charges contained in Patient A's complaint.

7. To support the charges in the Accusation, complainant relied exclusively on respondent's medical records of his care and treatment of Patient A, the CURES (Controlled Substance Utilization Review and Evaluation System) reports for Patient A, the transcript of respondent's interview by HQIU, and the testimony and reports of Dr. Chih, complainant's designated expert. (See Exs. 5, 6, 9, 10, 11.) Patient A did not testify at the hearing; the contents of her complaint to the Board are uncorroborated and therefore considered unreliable and inadmissible hearsay. (Gov. Code, § 11513.)

Respondent's Treatment of Patient A

8. Respondent provided medical treatment to Patient A from December 2015 to October 2018. When she started treatment with respondent, Patient A's medical records indicate she was 71 years old with a history of fibromyalgia, asthma, gastroesophageal reflux, peripheral neuropathy, and hypothyroidism. For nearly three years, respondent treated Patient A for a variety of ailments, including ear pain, anxiety, concussion, insomnia, upper respiratory symptoms, diarrhea, depression, sleep apnea, and osteoporosis. Complainant offered no evidence demonstrating respondent's treatment of Patient A caused her harm.

RESPONDENT'S CHARTING PRACTICES

9. Respondent used electronic records to document his treatment of Patient A. Those records were oftentimes confusing, inconsistent, incomplete, inaccurate, or misleading.

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10. Respondent's records for Patient A included the following conflicting information:

- On December 30, 2015, respondent's records state Patient A reports "not experience[ing] numbness or bone pain" but in a subsequent paragraph, respondent documented Patient A to have peripheral neuropathy manifested by "numbness of the arms." (Ex. 11, p. A111.)

- On February 1, 2016, respondent diagnosed Patient A with acute otitis media (i.e., an ear infection), but he documented the results from his exam of Patient A's ear that day as completely normal. (Ex. 11, p. A120.)

- On June 30, 2016, Patient A visited respondent for treatment of upper respiratory symptoms. (Ex. 11, p. A137.) However, respondent documented that Patient A was asymptomatic: she had no cough, wheezing, fever, nasal congestion, etc. (*Id.* at p. A137.) Respondent then noted his impression and assessment was "chronic cough." (*Id.* at p. A138.)

- On September 1, 2016, Patient A had tachycardia with a heart rate of 127, but respondent documented her heart exam revealed a "normal rate." (Ex. 11, p. A150.)

- On October 10, 2016, respondent documented that Patient A was taking zolpidem for insomnia, but the medical record also erroneously stated Patient A did not take other medications for insomnia (on February 11, 2016, respondent prescribed temazepam to Patient A for insomnia in addition to zolpidem). (Ex. 11, p. A155; see also p. A122.)

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- On March 1, 2017, respondent documented that Patient A was taking temazepam for insomnia, but had not tried other medications for insomnia. (Ex. 11, p. A176.) Yet, respondent's charts indicate Patient A had taken zolpidem as well in the past. (*Id.* at p. A155.)

- On November 6, 2017, respondent documented that Patient A had "never been on a medication for anxiety or depression." (Ex. 11, p. A225.) However, respondent prescribed the antidepressant Paxil to Patient A at her April 3, 2017 appointment and Wellbutrin SR at her April 10, 2017 appointment. (*Id.* at pp. A190, A192.) Respondent's plan for Patient A was to change her Wellbutrin SR prescription to Lexapro. (*Id.* at p. A226.)

11. It was difficult to decipher from respondent's records what medications Patient A used on a given date. For instance, respondent prescribed Bactrim for an ear infection on February 1, 2016. (Ex. 11, p. A120.) However, the medication was listed on the "current medication log" in Patient A's records through June 23, 2016, even though the infection had resolved well before then. (*Id.* at p. A134.) Likewise, respondent documented he discontinued prescribing Wellbutrin on November 6, 2017 (*id.* at p. A226); however, the medication was listed on Patient A's "current medication log" for four subsequent visits through December 11, 2017. (*Id.* at p. A234.)

12. Patient A's medical records contain notes from earlier visits cut and pasted out of context. For example, respondent appears to have copied and pasted the plan for Patient A's acute gastroenteritis from December 30, 2015, into Patient A's records of her visits on January 11, 2016, February 11, 2016, and May 18, 2016. The charts do not indicate Patient A was suffering from acute gastroenteritis on those later dates. (Ex. 11, pp. A115, A117, A124, A129.)

13. Respondent did not address Patient A's abnormal heart rates on two visits. For instance, on September 1, 2016, Patient A had a heart rate of 127, and on December 6, 2017, Patient A had a heart rate of 117. (Ex. 11, pp. A150, A232.) However, respondent's records make no mention of these findings or include a plan to address them.

14. Respondent's medical records fail to explain the basis for certain treatments administered or recommended to Patient A. According to those records, respondent gave Vitamin B12 injections to Patient A on January 11, February 1, February 11, March 15, and May 18, 2016, as well as several other times throughout Patient A's treatment. (E.g., Ex. 11, pp. A118, A120, A124, A126, A129) However, respondent did not document that Patient A suffered from any Vitamin B12 deficiency or why Patient A needed the shots. Similarly, respondent did not document why Patient A should use ibuprofen for asthma as noted in her February 11, 2016 record. (*Id.* at p. A124.) Respondent likewise failed to document why he repeatedly prescribed Solu-Medrol, a steroid, for Patient A's upper respiratory tract infection or her dry cough. (See, e.g., *id.* at p. A126.) And, it was unclear from respondent's notes why he recommended a certain diet, exercise regimen, and fall precautions for Patient A's hypothyroidism. (*Id.* at p. A174.)

RESPONDENT'S PRESCRIPTION PRACTICES

15. Respondent prescribed temazepam (a benzodiazepine) and zolpidem for several months in combination to Patient A to treat her insomnia. (Ex. 9, p. A57; Ex. 11, p. A197.) At the same time, Patient A's medical records indicate she was taking muscle relaxants and sedating antihistamines. Respondent's records do not reflect any discussions respondent may have had with Patient A regarding the risks of taking these medications at the same time.

RESPONDENT'S TREATMENT OF PATIENT A'S OTITIS MEDIA

16. On February 1, 2016, Patient A presented to respondent with bilateral ear pain, facial pain, and nasal discharge. Respondent examined Patient A's head, eyes, ears, nose, and throat (a HEENT exam) and documented his findings as normal. (Ex. 11, p. A120.) Nevertheless, respondent diagnosed Patient A with acute otitis media and prescribed the antibiotic Bactrim to treat the infection. (*Ibid.*)

RESPONDENT'S BREAST EXAMS OF PATIENT A

17. As part of his annual exam, respondent performed a breast examination on Patient A on March 1, 2017, and March 21, 2018. (Ex. 11, pp. A180, A255.) His notes for these exams do not indicate whether he obtained informed consent to perform the exams or offered Patient A to have a chaperone in the room. The records do not indicate Patient A consented to or objected to the exams.

Respondent's Interview Testimony

18. During his HQIU interview, respondent stated his DEA licenses were in good standing and he had never been disciplined by the Board. He has not had any civil or malpractice cases filed against him in the past five years. He has never been arrested or convicted of a crime.

19. Respondent also stated he graduated from a four-year medical school and completed his internship and residency in family medicine. He became Board-certified in family medicine in 2008, and he has continued his certification to date. Respondent has had hospital privileges at Desert Regional Medical Center since 2008.

20. Respondent has had a solo practice since 2008. He treats neonates to geriatric patients. He also practices addiction medicine. Respondent sees 25 to 40

patients a day, and he is on call seven days a week, 24 hours a day. Respondent does not supervise any nurse practitioners or physician assistants. He works with a medical assistant, office manager, administrative assistant, and receptionist.

21. When asked about his record keeping, respondent told the interviewers that it took some time to get used to the electronic record keeping system he now uses. (Ex. 10, p. A86.) He acknowledged he sometimes failed to click the proper entries presented by the software and was aware the defaulted entries were not always accurate. He then forgot to correct the record. (*Id.* at p. A85.) Respondent indicated the current medication lists in the electronic records do not reflect the medication a patient is currently taking but instead identify all of the medications prescribed. Periodically, respondent or his medical assistant reviews and updates the list by deleting medications the patient no longer takes. (*Ibid;* also p. A100.)

22. Respondent told the interviewers Patient A came to his practice already taking Ativan (a benzodiazepine), Flexeril (a muscle relaxant), temazepam, and zolpidem. (Ex. 10, p. A82.) Respondent was not "comfortable" with Patient A's medications and attempted to change them so they would be more appropriate for Patient A's age and pathology. He reported Patient A was resistant to his proposed changes. (*Id.* at p. A103.) He also noted he could not wean Patient A off these medications abruptly without risk to her health. (*Id.* at p. A83.) Respondent stated he eventually was able to wean Patient A from Ativan completely but she insisted she needed both zolpidem and temazepam to sleep. (*Id.* at p. A103.) Respondent never observed any adverse effects of her use of the drugs on Patient A's personality.

23. Respondent was not asked in the HQIU interview about many of the inconsistencies found in his medical records, his use of Bactrim to treat Patient A's

acute otitis media, whether Patient A had consented to her annual breast exam, or his use of chaperones when examining Patient A or other female patients in his office.

Expert Testimony by Dr. Chih

24. Dr. Chih is Board-certified in internal medicine and nephrology. She graduated summa cum laude from the University of California, Los Angles, in 1994 with a Bachelor of Science in chemistry and biochemistry. She obtained her Doctor of Medicine and a Ph.D. from UCLA School of Medicine in 2003. She did an internal medicine internship and residency from 2003 to 2006 and a nephrology fellowship from 2006 to 2008, all at Kaiser Permanente Los Angeles Medical Center.

25. Dr. Chih has served as the Clinical Documentation Improvement Advisor for the City of Hope Medical Center (City of Hope) since January 2022. She also has been the Chief of the Division of Hospital Medicine at City of Hope since November 2020. Previously, Dr. Chih served as the lead hospitalist for the Veterans Health Administration and as the Chief, Section of Hospital Medicine at Veteran Affairs Loma Linda. Dr. Chih spends 40 to 50 percent of her time on administration and her remaining time on clinical practice. Most of her clinical practice is in a hospital setting with in-hospital patients. From her curriculum vitae, it appears Dr. Chih was in private practice as a nephrologist from 2008 through 2012. (Ex. 7.) She offered no testimony as to her experience providing sensitive exams to women patients in a non-hospital setting.

RECORD KEEPING

26. According to Dr. Chih, the standard of care requires a physician to keep timely, legible, and accurate medical records. Accurate recording of a physician's physical findings should be documented in every visit. There should be clear

documentation of impressions and plans. The medical records should contain a list of the medications a patient is currently taking to ensure patient safety and quality of care. (Ex. 5, p. A32.) Accurate and complete medical charting allows for meaningful continuity of care and provides a patient's future physicians with information regarding the patient's early conditions.

27. Dr. Chih's review of respondent's medical records for Patient A found those records often contained conflicting information, inaccurate medication information, and portions pasted out of context. The records also sometimes lacked an explanation of the rationale behind respondent's choice of treatment. (Ex. 6.) Additionally, Dr. Chih's review found respondent did not address certain abnormal findings or complaints in his assessment and plans. (*Ibid.*)

28. Dr. Chih testified she believed many of respondent's errors were due to his electronic record keeping system. However, because of the many inconsistencies and inaccuracies, it was difficult to discern what was accurate in the records. Although Dr. Chih opined such errors in isolation would constitute a simple departure of care, she further opined that when viewed in total, the number and nature of respondent's charting errors demonstrated an extreme departure from the standard of care. (Ex. 5, p. A32.)

CONCURRENT PRESCRIPTIONS OF TEMAZEPAM AND ZOLPIDEM

29. Respondent's medical records dated May 18, 2016, August 2, 2016, and November 14, 2016, reflect he prescribed Patient A temazepam and zolpidem to treat her insomnia. Temazepam is a benzodiazepine, a class of drugs that have hypnotic, anxiolytic, muscle relaxant, and anticonvulsant properties. Zolpidem is a

nonbenzodiazepine benzodiazepine receptor agonist, which has a different structure than a benzodiazepine and is commonly used for insomnia.

30. According to Dr. Chih, benzodiazepines such as temazepam should be used with caution because they can cause respiratory depression and are potentially addictive. Zolpidem and temazepam are not often used together particularly for elderly patients because they can aggravate certain conditions and increase the risk of falls. In addition, the two drugs used together can worsen obstructive sleep apnea and hypoventilation. (Ex. 5, p. A33.)

31. Dr. Chih opined respondent's concurrent prescribing of temazepam and zolpidem to Patient A constituted an extreme departure from the standard of care because Patient A suffered from asthma, chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea. (Ex. 5, p. A33.) Prescribing both medications concurrently placed Patient A at risk for respiratory compromise. The risk of adverse effects from the medications was compounded because respondent also prescribed muscle relaxants and sedating antihistamines at the same time. Dr. Chih further opined that a psychiatric consultation might have been warranted if respondent had trouble treating Patient A's condition.

32. At hearing, Dr. Chih testified the drug combination may have contributed to a fall reported by Patient A. She noted respondent took Patient A off of zolpidem only after she fell. However, respondent stated in his interview that Patient A was hit in the head with an umbrella, which caused her to fall and hit her head. (Ex. 10, p. A90.) Complainant offered no evidence showing the drugs prescribed by respondent to Patient A contributed to her fall.

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USE OF BACTRIM

33. Dr. Chih found respondent committed a simple departure from the standard of care by prescribing Bactrim for Patient A's acute otitis media. According to Dr. Chih, a diagnosis of otitis media is confirmed during an otoscopic exam by the presence of a bulging tympanic membrane (TM) and reduced mobility of the TM with pneumatic pressure. Respondent's exam of Patient A's ear, however, was reported to be normal; therefore Dr. Chih could not discern the basis of respondent's diagnosis. If Patient A did have an ear infection, Dr. Chih explained the standard of care for treatment was Augmentin, not Bactrim. Acceptable alternatives for patients with penicillin allergy include cephalosporins, doxycycline, azithromycin, or clarithromycin. Dr. Chih reported Bactrim is generally not used to treat ear infections due to a high rate of resistance to both *H. influenzae* and *S. pneumoniae* as well as ineffectiveness against Group A streptococcus. She opined Bactrim is generally ineffective for acute otitis media. (Ex. 5, p. A34.)

SENSITIVE EXAM

34. According to Dr. Chih, breast examinations for female patients are considered sensitive. In her report, Dr. Chih opined the standard of care when performing a female breast exam is to advise the patient of the exam, obtain permission for the exam, and offer a chaperone. She observed there was no documentation in Patient A's records of whether respondent offered a chaperone when he examined Patient A's breasts as part of his annual physical exams in 2017 and 2018. (Ex. 5, pp. A34–A35.)

35. Dr. Chih concluded respondent had not offered a chaperone to Patient A because Patient A, in her complaint to the Board, brought up concerns over being

alone in the exam room with respondent. (Ex. 5, p. A35.) She found respondent's failure to offer a chaperone constituted a simple departure from the standard of care. (*Ibid.*) However, Patient A's statements to the Board constitute hearsay, and no evidence was offered to support their reliability. Dr. Chih's conclusion respondent committed a simple departure from the standard of care predicated on her impressions from Patient A's uncorroborated statements therefore is not based on admissible evidence and is disregarded. (See *Pacific Gas & Electric Co. v. Zuckerman* (1987) 189 Cal.App.3d 1113, 1135–36 [expert conclusions based upon assumptions not supported by the record or upon "factors which are speculative, remote or conjectural, . . . [have] no evidentiary value"].)

36. At hearing, Dr. Chih addressed respondent's failure to document whether he offered a chaperone to Patient A. According to Dr. Chih, a prudent physician would have documented whether a chaperone had been offered to observe a breast exam. However, what is prudent may not equate to the standard of care. (See *Sinz v. Owens* (1949) 33 Cal.2d 749, 753 [standard of care requires the exercise of a reasonable degree of skill, knowledge, and care "not the highest skill medical science knows"].) And, no evidence was presented that Dr. Chih as a hospitalist had expertise in whether the standard of care required a family practitioner in 2017 and 2018 to document a patient's request for a chaperone. Her opinion on this issue therefore is disregarded. (See *id.* [An expert's competency to testify regarding the standard of care hinges on her "practical knowledge of what is usually and customarily done by physicians under circumstances similar to those" confronting a physician charged with negligence.]; *Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 947 [expert's qualifications must establish she has "the education, training, experience, or knowledge necessary to testify" to the standards of care].)

Absence of Rehabilitation Evidence

37. Respondent's refusal to participate in the hearing resulted in significant gaps in the evidence. No evidence was presented regarding whether respondent modified his record keeping practices since becoming aware of the Board's concerns. Respondent provided no explanation for his use of Bactrim to treat Patient A's ear infection. Nor was there evidence of what efforts, if any, respondent made to monitor Patient A's sleep medication and why he failed to refer her to a psychiatrist. There also was no evidence regarding steps respondent has taken to address the sensitivity of female breast exams. Finally, respondent failed to offer any statements or testimony vouching for his character or his medical skills.

Costs

38. Complainant requests reimbursement of $21,006.25 for costs incurred by the DOJ in pursuing this action. The costs consist of $20,346.25 for time spent working on the case through October 6, 2022, and an estimated $660 for time spent preparing the case up to the commencement of the hearing. According to the DOJ billing summary, complainant incurred 89 hours of attorney time, billed at $220 per hour, 3.5 hours of paralegal time, billed at $205 per hour, and .25 hours of analyst time for cost recovery. (Ex. 14.)

LEGAL CONCLUSIONS

Standard and Burden of Proof

1. Complainant has the burden of proof in an administrative action seeking to suspend or revoke a professional license, and the standard is clear and convincing

proof to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

2. Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

Governing Law and Legislative Intent

3. The Medical Practice Act governs the rights and responsibilities of the holder of a medical license. (Code, §§ 2000 et seq.) The state's obligation and power to regulate the professional conduct of its health practitioners is well settled. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 577.) Protection of the public is the highest priority for the Board in exercising its disciplinary authority and is paramount over other interests in conflict with that objective. (Code, § 2001.1.) In exercising disciplinary authority, the ALJ "shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence." (Code, § 2229, subd. (b).)

4. The Board is authorized to take action against any licensee who is charged with unprofessional conduct. (§ 2234.) Unprofessional conduct includes violation of any provision of the Medical Practice Act, gross negligence, repeated negligent acts, and inadequate and inaccurate record keeping. (*Id.,* subd. (a), (b), & (c); § 2266.)

5. "[A] physician is required to possess and exercise, in both diagnosis and treatment, that reasonable degree of knowledge and skill which is ordinarily possessed

and exercised by other members of his profession in similar circumstances." (*Landeros v. Flood* (1976) 17 Cal.3d 399, 408; see also *Bardessono v. Michels* (1970) 3 Cal.3d 780, 788.) Physicians are negligent if they depart from the standard of care, i.e., they fail to use the skill and care that a reasonably careful physician would have used in similar circumstances. (California Civil Jury Instructions No. 600.)

6. The standard of care for a physician can only be proved by expert testimony, unless the conduct required by the particular circumstances is within a layperson's common knowledge. (*Sinz, supra,* 33 Cal.2d at 753; see also *Alef v. Alta Bates Hospital* (1992) 5 Cal.App.4th 208, 215–219.) "The party offering the expert must demonstrate that the expert's knowledge of the subject is sufficient, and the determinative issue in each case is whether the witness has sufficient skill or experience in the field so his testimony would be likely to assist" the trier of fact. (*Alef, supra*, 5 Cal.App.4th at p. 219.)

Causes for Discipline

FIRST CAUSE FOR DISCIPLINE

7. The First Cause for Discipline seeks to discipline respondent's license for gross negligence in his care and treatment of Patient A. Specifically, complainant alleges respondent was grossly negligent in his medical record keeping and his concurrent prescribing of zolpidem and temazepam.

8. "'Gross negligence' long has been defined in California and other jurisdictions as either a 'want of even scant care' or 'an extreme departure from the ordinary standard of conduct.' [Citations.]" (*City of Santa Barbara v. Superior Court* (2007) 41 Cal.4th 747, 754; *Franz v. Board of Medical Quality Assurance* (1982) 31

Cal.3d 124, 138; *Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196–198.)

9. Complainant proved by clear and convincing evidence respondent's record keeping for Patient A constituted an extreme departure from the standard of care. Accurate charts are necessary to provide sound medical care to the patient in the future, and the failure to accurately chart a patient's care could jeopardize the patient's life and health. Respondent's medical records for Patient A were inconsistent and inaccurate. It was oftentimes difficult to discern the nature of Patient A's complaints, the basis for respondent's treatments, and the medication Patient A was taking. It would be difficult for a doctor treating Patient A to evaluate her care. The mistakes in the records were too numerous to constitute simple negligence. Cause therefore exists to discipline respondent's license for gross negligence under section 2234, subdivision (b). (Factual Findings 1–28; Legal Conclusions 1–8.)

10. Complainant proved by clear and convincing evidence respondent's concurrent prescription of zolpidem and temazepam constituted an extreme departure from the standard of care. Concurrently prescribing both medications with the addition of antihistamines and muscle relaxants to Patient A, who suffered from asthma, sleep apnea, and COPD, placed Patient A at potential risk. Cause therefore exists to discipline respondent's license for gross negligence under section 2234, subdivision (b). (Factual Findings 1–25, 29–32; Legal Conclusions 1–8.)

SECOND CAUSE FOR DISCIPLINE

11. The Second Cause for Discipline seeks to discipline respondent's license for repeated negligent acts under section 2234, subdivision (c). Those acts include the acts alleged as grossly negligent in addition to (1) respondent's alleged failure to

adequately treat Patient A's acute otitis media; (2) respondent's alleged failure to document whether he obtained permission to perform breast exams on Patient A, offered a chaperone, or obtained informed consent; and (3) respondent's alleged failure to assess Patient A and formulate a plan for her care and document his interactions with her.

12. A repeated negligent act involves two or more negligent acts or omissions. No pattern of negligence is required. (*Zabetian v. Medical Bd. of Cal.* (2000) 80 Cal.App.4th 462, 468.)

13. Complainant proved by clear and convincing evidence respondent's prescribing Bactrim for Patient A's acute otitis media constituted a simple departure from the standard of care. As explained by Dr. Chih, Bactrim is not considered effective against acute otitis media and respondent should have prescribed a more effective antibiotic to treat Patient A's infection. (Factual Findings 1–8, 16, 33; Legal Conclusions 1–6, 12.)

14. Complainant failed to prove by clear and convincing evidence respondent's failure to document whether Patient A consented to a breast exam as part of her annual physical or requested a chaperone during the exam constituted a departure from the standard of care in 2017 and 2018 when the exams took place. While such documentation might be considered a best practice, Dr. Chih's report did not make any such finding in her report, and there was no evidence Dr. Chih had the necessary background to support her testimony on the issue. (Factual Findings 1–8, 17, 24–25, 34–36; Legal Conclusions 1–6, 12.)

15. Complainant proved by clear and convincing evidence respondent acted negligently when he failed to assess Patient A's conditions and formulate a plan for

her care. Respondent failed to address Patient A's high heart rates on two occasions. He also failed to provide the rationale for prescribing a special diet for hypothyroidism, his prescribing of Solu-Medrol, and his routine Vitamin B12 injections. (Factual Findings 1–8, 13–14, 27–28; Legal Conclusions 1–6, 12.)

16. Based on respondent's acts of gross negligence, his negligent prescribing of Bactrim, and his negligent failure to assess Patient A's conditions, complainant proved by clear and convincing evidence that respondent engaged in more than two acts of negligence. Cause therefore exists to discipline respondent's license for violation of section 2234, subdivision (c). (Factual Findings 1–33; Legal Conclusions 1–13, 15.)

THIRD CAUSE FOR DISCIPLINE

17. The Third Cause for Discipline seeks to discipline respondent's license for failure to maintain accurate and adequate medical records under section 2266. Failure to maintain adequate and accurate patient records constitutes unprofessional conduct. (§ 2266.)

18. Complainant proved by clear and convincing evidence that respondent's medical records for Patient A were inaccurate and inadequate. Cause therefore exists to discipline respondent's license for violation of section 2266. (Factual Findings 1–28; Legal Conclusions 1–9.)

FOURTH CAUSE FOR DISCIPLINE

19. The Fourth Cause for Discipline seeks to discipline respondent's license for general unprofessional conduct based on his gross negligence, repeated acts of negligence, and his failure to maintain accurate and adequate medical records.

20. Complainant proved by clear and convincing evidence respondent committed gross negligence and repeated acts of negligence and failed to maintain accurate and adequate medical records. Cause therefore exists to discipline respondent's license under section 2234 for unprofessional conduct. (Factual Findings 1–33, Legal Conclusions 1–13, 15–19.)

Appropriate Discipline

21. In deciding whether and how to discipline a license, the Board shall take action calculated to aid in the rehabilitation of licensees, but only to the extent consistent with public protection. (§ 2229.) The Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th ed. 2016) (Guidelines) provides a range of recommended discipline for certain licensee misconduct. The Board may deviate from the Guidelines where the facts of the particular case warrant it. (Cal. Code Regs., tit. 16, § 1361, subd. (a).)

22. The Guidelines recommend discipline ranging from a minimum of five years of probation with terms and conditions to a maximum of revocation when a physician has been found to have committed unprofessional conduct, gross negligence, repeated acts of negligence, or failed to maintain accurate and adequate records. (Guidelines, p. 24.).

23. While the absence of rehabilitation evidence is concerning, respondent's misconduct does not require revocation of respondent's license for public protection considering the nature of the misconduct and the evidence of mitigation in the record. The causes for discipline involve a single patient who respondent treated more than four years ago. This is the first time in respondent's 14 years of practice his license is subject to discipline; no evidence of any subsequent complaints was offered. Although

respondent did not participate in the hearing of this matter, respondent was cooperative with the Board's investigation. In his HQIU interview, respondent demonstrated he was cognizant of the potential issues arising from his concurrent prescriptions of zolpidem and temazepam. He was also aware of the problems of his electronic record keeping. His misconduct was neither intentional nor calculated. (Factual Findings 18–22.)

24. Accordingly, the public will be adequately protected by placing respondent's license on probation for five years with terms and conditions allowing the Board to assess respondent's clinical skills, provide respondent the opportunity to improve those clinical skills, and ensure respondent's practice comports with the standard of care. These terms, including taking additional education courses, completing specific courses on prescribing practices and medical record keeping, participating in a clinical competence assessment program, and having a practice monitor, will allay any concerns about respondent continuing to practice on his own. There was insufficient evidence to justify the imposition of any term requiring respondent to take an ethics or professional boundaries course.

Costs

25. Effective January 1, 2022, the ALJ may direct a Board licensee found to have committed a violation or violations of the Medical Practice Act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. (§ 125.3, subd. (a).) Complainant requests reimbursement of $20,346.25 in actual costs of prosecution and enforcement and $660 in estimated costs. Complainant's request for reimbursement of $20,346.25 is reasonable and is granted. Complainant's request for reimbursement for estimated costs is denied. Complainant offered no evidence the

estimated costs were incurred. Thus, the request for estimated costs did not meet the standards set forth in California Code of Regulations, title 1, section 1042.

ORDER

Certificate No. A 104389 issued to respondent Edmund Ayoub, Jr., M.D., is revoked. However, the revocation is stayed, and respondent is placed on probation for five years upon the following terms and conditions.

1. EDUCATION COURSE

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the CME requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. PRESCRIBING PRACTICES COURSE

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any

information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. MEDICAL RECORD KEEPING COURSE

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's

expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. CLINICAL COMPETENCE ASSESSMENT PROGRAM

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require

respondent's on-site participation for a minimum of 3 and no more than 5 days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the respondent did not successfully complete the clinical competence assessment program, the respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

5. MONITORING PRACTICE

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

6. NOTIFICATION

Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

8. OBEY ALL LAWS

Respondent shall obey all federal, state, and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

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9. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. General Probation Requirements

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

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License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent

shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations.

13. COMPLETION OF PROBATION

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation.

Upon successful completion of probation, respondent's certificate shall be fully restored.

14. VIOLATION OF PROBATION

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. LICENSE SURRENDER

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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16. PROBATION MONITORING COSTS

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

17. COSTS

Respondent shall pay to the Board costs associated with its enforcement of this matter pursuant to Business and Professions Code section 125.3 in the amount of $20,346.25. Respondent shall be permitted to pay these costs in a payment plan approved by the Board, with payments to be completed no later than three months prior to the end of the probation term.

If respondent has not complied with this condition during the probationary term, and respondent has presented sufficient documentation of his good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may grant an extension of respondent's probation period up to one year without further hearing in order to comply with this condition. During the one-year extension, all original conditions of probation will apply.

DATE: 11/08/2022

CINDY F. FORMAN
Administrative Law Judge
Office of Administrative Hearings